(17) (16)

Nos. 89-1391 and 89-1392

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

DR. IRVING RUST, *et al.*,

Petitioners,

v.

DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services,

Respondent.

THE STATE OF NEW YORK, *et al.*,

Petitioners,

v.

DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN ACADEMY OF FAMILY PHYSICIANS, THE AMERICAN FERTILITY SOCIETY, THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC., THE AMERICAN PSYCHIATRIC ASSOCIATION, AND THE PHYSICIANS FOR REPRODUCTIVE HEALTH AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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QUESTIONS PRESENTED

Amici will address the following questions:

(1) Whether an agency may alter its longstanding interpretation of a statute in a manner that raises serious constitutional questions in the absence of any clear, affirmative evidence that Congress intended such an interpretation.

(2) Whether the Secretary's regulations violate the First Amendment's proscription against viewpoint discrimination.

(3) Whether the Secretary's regulations unduly burden and affirmatively interfere with a woman's fundamental right to make important medical treatment decisions.

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INTEREST OF *AMICI CURIAE*

Amici curiae are seven major organizations of health care professionals. *Amici* share an abiding dedication to promoting the public welfare through the maintenance of the highest professional standards and the provision of quality health care. *Amici*'s interest is not in debating the philosophical, ethical, moral or religious issues surrounding abortion. Indeed, their members hold divergent views on some of these issues.

The American College of Obstetricians and Gynecologists ("ACOG") is a private, voluntary, nonprofit organization of physicians who specialize in obstetric and gynecologic care. ACOG is the leading group of professionals providing health care to women. Its 29,500 members represent approximately 90% of all obstetricians and gynecologists practicing in the United States. ACOG believes that every person has a fundamental right to make individual medical treatment decisions free of unwarranted government interference, particularly interference with the type of information that a physician can provide to a patient who must make an important medical treatment decision.

The American Academy of Family Physicians ("AAFP") is a private, voluntary, non-profit professional organization, representing 69,000 family physicians throughout this country. The AAFP was founded in 1947 and was instrumental in the establishment of family practice as a primary medical specialty. The Academy's interest stems from the potentially significant impact of this case on the family physicians' responsibility to and relationship with the families they serve.

The American Fertility Society ("AFS") is a voluntary, nonprofit organization of over 10,000 physicians and scientists—the majority of whom are obstetricians-gynecologists—dedicated to advancing knowledge about and treating disorders of the reproductive system. AFS opposes laws that prevent physicians from offering all available, medically appropriate treatment options to their patients.

The American Medical Association ("AMA") is a private, voluntary, non-profit organization of physicians. The AMA was founded in 1846 to promote the science and art of medicine and to improve the public health. Its 280,000 members—over half of all physicians currently licensed to practice medicine—practice in all fields of medical specialization. The AMA opposes the regulations at issue to the extent that they will force physicians to deviate from accepted standards of medical practice and ethics. The AMA has concluded that it is not necessary to reach the constitutional issues presented in this case that are addressed in this brief in Parts II and III of the Argument. Nevertheless, to avoid filing a separate brief, which would burden "the staff and facilities of the Court," Sup. Ct. R. 37.1, the AMA joins the brief subject to the limitation described above.

The American Medical Women's Association, Inc. ("AMWA"), founded in 1915, is a nonprofit organization of 12,000 women physicians and medical students, one of whose primary missions is to promote quality health care for women. AMWA strongly opposes laws which adversely affect the health of women, or impose constraints on the right of the pregnant patient, in consultation with her physician, to make a personal and medically informed decision whether or not to continue a pregnancy.

The American Psychiatric Association ("APA") is the nation's largest professional association specializing in psychiatry, with a membership exceeding 30,000 physicians. APA's purposes include promoting the welfare of patients who require psychiatric services.

The Physicians for Reproductive Health is a private, voluntary, nonprofit organization of more than 700 physicians and medical students. The primary mission of its membership is to highlight issues that will improve the availability and quality of reproductive health care.

Under a longstanding interpretation set forth by the Secretary of Health and Human Services (Secretary) implementing Title X of the Public Health Service Act, 42 U.S.C. §§ 300-300a-41 (1982) ("Title X"), physicians in Title X programs have been able to provide family planning assistance in accordance with accepted ethical and legal standards of medical care. The Secretary promulgated new regulations in 1988, however, which prohibit Title X physicians from providing medically appropriate counseling and referrals, and which threaten seriously to compromise the health of patients that many of *amici*'s members serve. The Secretary's scheme also would impose upon physicians an intolerable choice—either to comply with conditions that contravene fundamental medical principles and requirements of state law or forgo providing vital health services to those who desperately need them. In light of these serious threats to patient health and the integrity of medical practice, *amici* wish to present their views.[1]

STATEMENT

Title X provides substantial funding—on average 50 percent of operating costs—to over 3900 family planning clinics nationwide. Pet. App. 78a-79a (Morley ¶ 6). These clinics, which also are supported by state, local and private funds, serve 4.5 million women each year. *Id.* The women who come to these clinics typically have no other source for nonemergency health care. *Id.* at 78a (Joseph ¶ 5); 85a (Fink ¶ 10). The vast majority have very low incomes, and approximately one-third are adolescents. Supp. Pet. 4sa.

Family planning clinics provide their patients with a wide range of vital medical services. In addition to information and counseling regarding contraception, family planning clinics must provide "general repro-

[1] Pursuant to Rule 37 of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Clerk of the Court.

ductive health care," including "physical examinations, screening for breast cancer [and] treatment of gynecological problems," 53 Fed. Reg. 2922, 2926-27 (1988), as well as diagnostic tests (*e.g.*, pap smears, cultures, and blood tests) for a variety of diseases (*e.g.*, cancer, gonorrhea, AIDS). Pet. 4 n.5. Clinics also must provide a range of infertility services, including "education, examination, appropriate laboratory testing, counseling and appropriate referral." 53 Fed. Reg. at 2926. Finally, clinics must provide pregnancy tests—a common reason for many initial visits—and "facilitate access to prenatal care and social services." *Id.* at 2927.

In providing federal funds to family planning clinics, Congress intended to ensure that a low-income woman would not be denied access to these basic medical services "because of her economic condition." H.R. No. 91-1472, 91st Cong., 2d Sess., *reprinted in* 1970 U.S. Code Cong. & Admin. News 5068, 5073. Consistent with this intent, the clinics are staffed by fully licensed physicians and counselors who provide services that are consistent with the basic principles of medical care and that are subject to the basic requirements of state law in regulating the quality of those services.

A. Medical Background

A fundamental principle of medical ethics, which applies equally to the health care services offered in family planning clinics as in any other context, is that physicians must respect the autonomy of the patient. At its most basic level, respecting a patient's autonomy means recognizing that "[t]he patient should make his own determination on treatment." *Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association* (hereinafter "AMA Opinions") ¶ 8.08 (1989). This principle, which has deep roots in the medical tradition, is grounded solidly in the common law. *Cruzan* v. *Director*, No. 88-1503, slip op. at 5 (June 25, 1990). It is also the foundation for other ethical and legal obligations imposed upon the physician.

Central among these is the requirement that a physician must provide a patient with all information necessary for the patient to make an informed decision about whether to pursue a given treatment. As ACOG has stated:

> The principle of autonomy requires that a patient be given complete and truthful information about her medical condition and about any proposed treatment. Only with such information is she able to exercise her right to make choices about health care.

ACOG, *Ethical Decision-Making in Obstetrics and Gynecology*, Technical Bulletin No. 136, 3 (Nov. 1989); see AMA Opinions ¶ 8.08 (the "physician's obligation is to present the medical facts accurately to the patient"). Through the doctrine of informed consent, the ethical obligation fully to disclose the relevant medical information "has become firmly entrenched in American tort law." *Cruzan*, slip op. at 5. See, *e.g.*, *Unthank* v. *United States*, 732 F.2d 1517, 1521 (10th Cir. 1984) (physician must disclose "any material information important to choosing a course of treatment").

Similarly entrenched in the common law and medical ethics are the responsibilities that flow from the trust on which the physician-patient relationship is based. "Because patients must be able to rely on their physicians to act in good faith and in their best interest," the common law treats the duties owed by doctors to patients as "fiduciary" in nature. Pet. App. 84a, Katz ¶ 7; see *Lambert* v. *Park*, 597 F.2d 236, 239 n.7 (10th Cir. 1979). Once having begun to serve a patient, a physician is ethically and legally obligated to speak honestly with that patient. *E.g.*, *Natanson* v. *Kline*, 350 P.2d 1093, 1102-03 (Kan. 1960). In particular, physicians' "high ethical obligation to avoid coercion and manipulation of their patients" requires physicians to avoid "the withholding or distortion of information in order to affect the patient's beliefs and decisions." 1 President's Commission for the Study of Ethical Problems

in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions* 68, 67 (1982).

Finally, it is fundamental to sound medical practice that a physician never neglect or abandon a patient under his or her care. AMA Opinions ¶¶ 3.5, 8.10; Pet. App. 83a-84a (Katz ¶ 6). Regardless of what particular services a physician may directly provide, a physician must inform a patient of all medical services that a patient might reasonably consider.[2] Should the patient request or require medical services that the physician lacks " 'the requisite skill, knowledge, or facilities' " to provide, the physician is obligated " 'to advise his patien[t] to consult a specialist.' " *Dewes* v. *Indian Health Servs.*, 504 F. Supp. 203, 208 (D.S.D. 1980) (quoting J. Director, 35 ALR 3d 349, 358 (1971)); see *Haley* v. *United States*, 739 F.2d 1502, 1507 (10th Cir. 1984) (physician has a duty to refer to specialist). Such referrals must be made only to competent and appropriate providers. AMA Opinions ¶ 3.04.

Each of these fundamental principles finds important and regular application in the family planning context. The need for trust and candor in the physician-patient relationships in a Title X clinic is particularly acute, because these clinics provide the only non-emergency health care treatment many of their patients will receive. For a typical patient, a physician might perform a general physical examination and diagnostic tests. Should any abnormalities be detected, the physician would be obliged to explain these findings to the patient, explain the alternatives available, and provide the service selected by the patient or refer the patient to an appropriate provider.

[2] While the Secretary correctly states that an individual physician may, consistent with medical ethics, refrain from providing a particular *treatment*, he errs in concluding that there is nothing medically unethical about the government restricting physicians from providing *information and counseling about a particular treatment*. 53 Fed. Reg. at 2929. A physician may not deprive a patient of information regarding medically appropriate treatments needed to make a fully informed medical decision, even if the information concerns treatments that the physician does not perform. For example, it would be medically unacceptable for an oncologist not to disclose or discuss with cancer patients the possibility of surgery merely because the physician performs only radiation and chemotherapy. See Pet. App. 83a (Rosenfield ¶ 22); see *Smith* v. *Karen S. Reisig, M.D., Inc.*, 686 P.2d 285 (Okla. 1984).

From a medical perspective and as a matter of state law, the termination of a pregnancy is one of the therapeutic and legally available alternatives that a physician may, and in some cases must, discuss with a pregnant woman. Providing information promptly about all medical options, including abortion, becomes imperative for women suffering from a medical condition that is exacerbated by continuation of pregnancy, and for whom pregnancy may pose serious health risks. Pet. App. 81a (Sammons ¶ 8). For example, for the 1.5 million women of child-bearing age who suffer from diabetes, the risks of pregnancy include a fourfold increase in the likelihood of hypertensive disease, an increase in the likelihood and severity of infection, and increased incidence of complications during and following delivery. R. Creasy & R. Resnik, *Maternal-Fetal Medicine* 925 (2d ed. 1989); J. Pritchard, P. MacDonald & N. Grant, *Williams Obstetrics* 600 (17th ed. 1985). Pregnancy also poses significant health risks for women suffering from a neurologic disease such as multiple sclerosis, myasthenia gravis, post-poliomyelitis or epilepsy, as well as for women with certain types of renal disease or sickle cell disease. J. Butler & D. Walbert, *Abortion, Medicine, and the Law* 253 (3d ed. 1986). The risks are even more serious for women with certain cardiovascular disorders, such as primary pulmonary hypertension or congenital heart disease, for whom pregnancy creates "a high risk of major disability and death." *Management of High-Risk Pregnancy* 289-90 (J. Queenan ed. 2d ed. 1985).

For women with cancer, the second leading cause of death among women in their reproductive years, pregnancy poses especially serious and complex risks. Preg-

nancy may mask the cancerous condition, exacerbate the disease process, and increase the spread of tumors in the pregnant woman. E. Friedman, D. Acker & B. Sachs, *Obstetrical Decision Making* 62 (2d ed. 1987); see Williams & Bitran, *Cancer and Pregnancy*, 12 Clin. Perinat. 609 (1985). Moreover, because radiation treatment or chemotherapy is likely to cause severe fetal malformation or death, a pregnant woman with cancer who could benefit from such treatments will have to choose between protecting her health or that of her fetus.[3] Although the actual risks posed by pregnancy will vary depending on the individual and the nature of her complicating conditions, these examples illustrate how serious the risks may be.

Discussion between physician and patient of the full range of options, including the availability of abortion services, will be appropriate in other circumstances as well. Most typically, a patient may ask about the availability of abortion services when a pregnancy is unplanned and unwanted. Tragically, a significant number of clinic patients learn each year that they are pregnant as a result of rape. Pet. App. 90a (Drisgula ¶ 24); 91a (Potteiger ¶ 18). In these and other circumstances,[4] the medical specialty society of physicians whose practice is

[3] See S. Cherry, R. Berkowitz & N. Kase, *Rovinsky & Guttmacher's Medical, Surgical & Gynecological Complications of Pregnancy*, 512-15 (3d ed. 1985); *Obstetrical Decision Making* at 62.

[4] Options counseling is appropriate also when discussing the potential for the birth of a child with severe physical or mental abnormalities, which may result from a mother's pre-existing health condition, from the use of medications, from the mother's exposure to infection (notably AIDS or rubella), or from inherited genetic disorders. See generally *Abortion, Medicine, and the Law* at 253-55; *Obstetrical Decision Making* at 74-81. In such cases, the physician is ethically and legally obliged to inform the patient of the potential risks to the fetus, and promptly to provide or refer the patient for appropriate counseling to enable the patient to make informed decisions regarding the management or termination of her pregnancy. ACOG, *Ethical Issues in Pregnancy Counseling*, Committee on Ethics Opinion No. 61 (March 1988). See *supra* p. 5.

most directly involved in this case imposes a professional obligation on the physician to inform the patient of all options:

> In the event of an unwanted pregnancy, the physician should counsel the patient about her options: 1) continuing the pregnancy to term and keeping the infant, 2) continuing the pregnancy to term and offering the infant for legal adoption, or 3) aborting the pregnancy.

ACOG's *Standards for Obstetric-Gynecologic Services* 62 (7th ed. 1989). The physician must also refer the patient to an appropriate provider, particularly when delay in obtaining proper care may pose or exacerbate serious risks to the patient's health. *E.g.*, *Rise* v. *United States*, 630 F.2d 1068, 1073 (5th Cir. 1980); *Keir* v. *United States*, 853 F.2d 398, 413-14 (6th Cir. 1988).

But these are not solely matters of medical ethics, they are also governed by state law. Thus, a physician who has a pregnant patient with a serious, but not life-threatening health problem such as diabetes, must disclose to the patient the risks of pregnancy and the option of abortion or risk incurring liability or even professional discipline under state law for failure to comply with state law standards of care. See *infra* p. 16.

B. Impact of the New Regulations on Medical Practice

1. When it passed Title X in 1970, Congress declared its intent to "make comprehensive family planning services readily available to all persons desiring such services." 42 U.S.C. § 300. To that end, Congress authorized the Secretary of the then-Department of Health, Education, and Welfare "to make grants to . . . voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services." 42 U.S.C. § 300(a).

In Section 1008, Congress prohibited the Secretary from awarding funds to any "programs where abortion

is a method of family planning." 42 U.S.C. § 300(a-6). From 1971 until 1988, the Secretary consistently interpreted § 1008 not to prohibit medically appropriate abortion-related counseling and referral. See Pet. App. 71a-73a (excerpting relevant program guidelines and legal memoranda); see also *Valley Planning Clinic* v. *North Dakota*, 661 F.2d 99 (8th Cir. 1981).

2. On February 2, 1988, the Secretary promulgated amendments to the regulations that preclude Title X projects from making any non-pejorative statements regarding abortion. 53 Fed. Reg. 2922 (1988); Pet. App. 1a-8a. Section 59.8 is entitled "Prohibition on counseling and referral for abortion services." This section prohibits abortion counseling (§ 59.8(a)(1)), referrals to abortion providers (§ 59.8(a)(2), (3)); and provision of lists that contain names or addresses of providers who principally perform abortions § 59.8(a)(3)). This section also requires the project to provide patients with "information necessary to protect the health of mother and unborn child" until such time as a referral appointment is kept with one of the approved providers of prenatal care. § 59.8(a)(2). The Final Rule makes clear the sweeping nature of the ban on abortion-related expression. See 53 Fed. Reg. at 2936, 2938.[5]

In addition, the Secretary enacted regulations to ensure that Title X projects would not be able to provide patients with information about abortion through project activities other than counselling or referral. Section 59.10 prohibits Title X projects from engaging in any communicative activities that would "encourage, promote or advocate abortion." Section 59.9 requires a Title X project to be "physically and financially separate . . . from activities which are prohibited under Section 1008 of the Act, and [under] § 59.8 and § 59.10 . . . ."

The new regulations preclude physicians from acting in accordance with their ethical and legal obligations. Pet. App. 79a (Morley ¶ 18); 81a-82a (Sammons ¶¶ 4, 16); see *infra* p. 16. Physicians are still required to provide comprehensive "general reproductive health care," including physical examinations and diagnostic testing. Thus, they are still required to provide the kind of care that triggers the ethical and legal obligations imposed by the physician-patient relationship. If, in the course of providing such care, however, the physician discovers that a woman is pregnant, or has a complicating condition such that pregnancy poses a serious health risk, or that the woman's pregnancy is even the result of rape, the physician is nevertheless precluded from informing the patient about all of her legally available medical options, from providing complete answers to her questions, or even from referring her to another source for obtaining the information she seeks.

To return to the example discussed previously, a physician in a Title X clinic confronted with a pregnant patient with diabetes will invariably face the choice of complying with the Secretary's regulations and thereby face state law tort or disciplinary consequences, or complying with state law and protecting the patient's health and in the process jeopardize the entire clinic and deprive hundreds of women of access to affordable health care. The question is whether Congress intended to impose this awful dilemma upon physicians when it enacted Title X.

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[5] The sweep of the ban is confirmed by 1) the Title of § 59.8; 2) the single narrow exception for "cases in which emergency care is required," § 59.8(a)(2); and 3) the regulations' illustrative examples. The Secretary has limited the emergency exception to referrals for immediately "life-threatening" situations, such as ectopic pregnancy; thus precluding referral and counseling that includes abortion in the many situations where pregnancy poses serious, but not life-threatening, health risks. See 53 Fed. Reg. at 2239; § 59.8(a)(4) (prohibiting even "medically necessary" counseling regarding abortion services); see also § 59.8(b)(5) (government-approved response to a patient's request for abortion counseling or referrals is: "the project does not consider abortion an appropriate method of family planning *and therefore* does not counsel or refer for abortion") (emphasis added).

SUMMARY OF ARGUMENT

I.

The court of appeals erred in addressing the Secretary's authority to issue the challenged regulations under the deferential standard of review established in *Chevron U.S.A.* v. *NRDC*, 467 U.S. 837 (1984). Where, as here, an agency's interpretation raises serious constitutional questions, this Court has repeatedly held that it will not defer to that interpretation if another reasonable interpretation is available that would avoid the need to resolve those questions. *DeBartolo Corp.* v. *Florida Gulf Coast Trades Council*, 485 U.S. 568, 574 (1988); *NLRB* v. *Catholic Bishop*, 440 U.S. 490, 499-501, 504 (1979). Here, as in *Catholic Bishop*, there can be no dispute regarding the availability of an alternative interpretation for the Secretary himself employed just such an interpretation for the first 18 years following the passage of the Act. Here, too, the statutory language and legislative history are devoid of any clear evidence that Congress intended the Secretary to adopt his new, expansive interpretation. Accordingly, this Court should reject the Secretary's interpretation as outside the scope of his authority, and adopt a construction that does not raise constitutional concerns.

II.

The new regulations plainly violate the First Amendment proscription against viewpoint discrimination. Although government may choose to subsidize some activities but not others in order to further a partisan political agenda, *e.g.*, *Harris* v. *McRae*, 448 U.S. 297 (1980), government may not condition the subsidies on the recipients' agreement to espouse one viewpoint and not another. *Regan* v. *Taxation With Representation*, 461 U.S. 540, 548 (1983).

Although the court of appeals did not disagree with this principle, it plainly erred in concluding that the challenged regulations did not discriminate on the basis of

viewpoint. Section 59.10, for example, does not forbid recipients from engaging in categories of activities (such as lobbying or public speaking), but precludes them from *promoting abortion* through activities such as lobbying or public speaking. Other types of lobbying or public speaking, including anti-abortion expression, are not prohibited. Section 59.8 goes even further: it requires physicians to tell patients the government's view about what she should do in the event of pregnancy (*i.e.*, seek proper prenatal care from a provider that does not principally provide abortions). By specifying the views that fund recipients may and may not express on a single subject—medical treatment for pregnancy—the regulations impermissibly discriminate on the basis of viewpoint. Compare *Cornelius* v. *NAACP*, 473 U.S. 788, 806 (1985).

III.

Finally, the Secretary's regulations affirmatively interfere with and unduly burden a woman's right to make an informed medical decision concerning whether to terminate her pregnancy. Given the assumption of trust that underlies the physician-patient relationship, regulations ordering physicians to provide patients with selective information about the range of legal and medically appropriate treatment alternatives available to them are likely seriously to mislead many patients. This misinformation also will cause women to suffer increased health risks due to delay in obtaining a medically complete evaluation of their condition and options. No legitimate governmental interest is served by regulations that impose these "obstacles in the path of a woman's exercise of her freedom of choice." *Harris* v. *McRae*, 448 U.S. 297, 316 (1980).

ARGUMENT

I. THE CHALLENGED REGULATIONS EXCEED THE SCOPE OF THE SECRETARY'S AUTHORITY UNDER TITLE X.

In addressing the question of the Secretary's authority to issue the amended regulations, both the Second Circuit and the First Circuit erroneously analyzed the case under the deferential standard of review established in *Chevron U.S.A.* v. *NRDC*, 467 U.S. 837-842-45, & n.9 (1984). See Pet. App. 46a; Supp. Pet. App. 8sa. Under *Chevron*, the Secretary's interpretation "would normally be entitled to deference unless that construction were clearly contrary to the intent of Congress." *DeBartolo Corp.* v. *Florida Gulf Coast Trades Council*, 485 U.S. 568, 574 (1988).

"Another rule of statutory construction, however, is pertinent here: where an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress." *Id.* at 575 (citing *NLRB* v. *Catholic Bishop*, 440 U.S. 490, 499-501, 504 (1979). In these circumstances, the burden is on the agency to demonstrate "the affirmative intention of the Congress clearly expressed" to require such an interpretation before the Court will reach the constitutionality of the agency's interpretation. *Id.* at 501, 504, 506; see *Public Citizen* v. *Department of Justice*, 109 S.Ct. 2558, 2579 (1989) (requiring "firm evidence" of congressional intent). Accordingly, this Court has repeatedly rejected an agency's construction of a statute when another constitutionally benign construction was fairly available. *E.g.*, *DeBartolo Corp.* 485 U.S. at 574-588; *Catholic Bishop*, 440 U.S. at 499-506; *Hannegan* v. *Esquire, Inc.*, 327 U.S. 146, 156 (1946); *id.* at 160 (Frankfurter, J., concurring).

There can be no doubt that the Secretary's construction of Section 1008 raises serious constitutional questions.

The fact that one court of appeals, en banc, has voided the regulations on constitutional grounds is proof enough that the First and Fifth Amendment questions raised are substantial. Supp. Pet. App. 2sa-3sa. See *infra*, pp. 17-29.

Moreover, the Secretary's new regulations raise additional and serious concerns under the Supremacy Clause. As the Secretary has acknowledged, informed consent law in over 40 states requires that physicians disclose fully and accurately all information necessary for their patients to make voluntary and informed decisions about treatment options. 53 Fed. Reg. at 2929. And as discussed above, state law imposes a duty on physicians to refer patients to appropriate providers. See *supra* p. 6. Acknowledging that the new regulations may preclude physicians from complying with these state laws, the Secretary expressly stated an intent to preempt those laws: "[T]o the extent these regulations are inconsistent with the provisions of State law regarding counseling and informed consent, they may, in some circumstances, supersede State law under the Supremacy Clause of the Constitution." 53 Fed. Reg. at 2933.

These Supremacy Clause questions, no less than the other constitutional issues, are ones that should be avoided absent clear congressional intent to the contrary. The Court has long held that state law is presumed to coexist with federal regulation, and that preemption should not be inferred. *Ray* v. *Atlantic Richfield Co.*, 435 U.S. 151, 157 (1978). This principle applies with particular force in areas of traditional state concern, such as health care and medical services. *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947); *cf. Bowen* v. *American Hospital Ass'n*, 476 U.S. 610, 643-44 (1986) (plurality opinion). Accordingly, when an agency adopts a construction of a statute that may cause wide conflict with such state law, *Catholic Bishop* as well as basic preemption principles require the agency to provide affirmative and clear evidence that Congress intended to permit such an intrusion into state law.

While the Secretary seemed to assume that the potential for conflict between his interpretation of Title X and state law was not significant, his assessment of this point underestimates the breadth of a physician's exposure to liability for failure fully to inform a patient about treatment options. There are at least two common causes of action: First, any woman who suffers an adverse health effect because of her pregnancy who was not informed about an abortion or not properly referred to a physician who could provide her with that information will be able to sue the physician in the Title X clinic who failed directly or indirectly to bring the matter of an abortion to her attention. Second, any woman who gives birth to a severely impaired infant may sue for failure to disclose information that would have led her to choose an abortion. The former type of lawsuit is probably a viable claim as a form of medical malpractice in nearly all 50 states and the latter may be available in more than a dozen states. See, *e.g.*, D. Louisell & H. Williams, *Medical Malpractice* ¶¶ 22.03, 19.15 & n.10 (rev. ed. 1984 & Supp. 1990); *Phillips* v. *United States*, 566 F. Supp. 1, 8, 12-14 (D.S.C. 1981).

Here, there is no evidence that Congress intended the Secretary or the courts "to press ahead into [these] dangerous constitutional thickets . . . ." *Public Citizen*, 109 S.Ct. at 2572. Section 1008 prohibits the Secretary from disbursing federal funds only to family planning "programs where abortion is a *method* of family planning." 42 U.S.C. § 300a-6 (1982). The statute simply does not speak to the question whether the availability of abortions may be discussed as part of state law-required counseling or referral services.

There is no reason to reach the constitutional issues posed by the Secretary's new interpretation, because the Secretary's former interpretation of § 1008 is available and avoids completely all of the concerns raised by his new interpretation. Compare *Catholic Bishop*, 440 U.S. 490, 497 (NLRB's original interpretation did not raise constitutional questions). The Secretary's original interpretation is amply supported both by the plain language of the statute and the legislative history.[6] In promulgating the new regulations, the Secretary did not attempt to show that the new interpretation was compelled by the statute or legislative history. Nor could he. Because the challenged regulations raise serious constitutional questions, this Court should adopt the Secretary's original construction of Section 1008.

II. THE CHALLENGED REGULATIONS VIOLATE THE FIRST AMENDMENT RIGHTS OF FAMILY PLANNING PROVIDERS AND THEIR PATIENTS.[7]

The government's discretion in awarding benefits and privileges, though considerable, remains subject to First Amendment constraints. The government may decline to subsidize speech activities, but it may not administer its subsidies in a manner that discriminates on the basis of viewpoint and suppresses disfavored ideas. *Regan* v. *Taxation With Representation*, 461 U.S. 540, 549 (1983). The challenged regulations violate this principle.[8]

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[6] See, *e.g.*, Pet. App. 70a (S. Rep. No. 1004, 91st Cong., 2d Sess.) ("[A] successful family planning program must contain the following components: (1) Medical services, including consultation, examination, prescription and continuing supervision, supplies, instruction and referral to other medical services as needed"); H.R. Rep. No. 1161, 93d Cong., 2d Sess. 18 (1974) (physicians expected to disclose "any appropriate alternative methods or procedures that might be advantageous"); S. Rep. No. 29, 94th Cong., 1st Sess., *reprinted in* 1975 U.S. Code Cong. Admin. News 469, 524.

[7] In the view of *amicus* American Medical Association ("AMA"), it is not necessary to reach the constitutional issues addressed in parts II and III in order to resolve this case and it takes no position on those issues. Nevertheless, for the convenience of the Court, the AMA joined the previous sections rather than file separately. Sup. Ct. R. 37.1.

[8] *Amici* agree with the First Circuit (see Supp. Pet. App. 35sa, 39sa) that the challenged regulations are unconstitutional for a second, independent reason: they withhold a subsidy as a penalty for a potential grantee's independently funded speech, see *Perry* v. *Sindermann*, 408 U.S. 593, 597 (1972), and they do not provide a practical separation option. *FCC* v. *League of Women Voters*,

1. This Court has repeatedly upheld "[t]he general principle . . . that the First Amendment forbids the government to regulate speech in ways that favor some viewpoints or ideas at the expense of others." *City Council* v. *Taxpayers for Vincent*, 466 U.S. 789, 804 (1984) (citing cases). Indeed, there regularly is unanimity on the need to enforce the First Amendment's prohibition against viewpoint discrimination.[9]

At the same time, this Court also has established the basic principle that the Constitution does not require Congress "to subsidize the exercise of a fundamental right." *Regan*, 461 U.S. at 549. Accordingly, the Court has held that Congress may decline to subsidize certain categories of activities, such as lobbying, (*id.*; *Cammarano* v. *United States*, 358 U.S. 498, 513 (1959)); certain types of medical procedures, such as abortions, (*Maher* v. *Roe*, 432 U.S. 464 (1977); welfare benefits, (*Lyng* v. *International Union*, 108 S.Ct. 1184 (1988));

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468 U.S. 364, 400-01 (1984). *Amici* note that in the context of physician-patient counseling any physical separation requirement is inherently burdensome on First Amendment rights. Physician-patient communication requires a full exchange of information between particular individuals at a particular time. Permitting the physician to speak freely on some other occasion in some other facility to some other patient does not preserve the First Amendment rights of either doctor or patient.

[9] See, *e.g.*, *FCC* v. *League Of Women Voters*, 468 U.S. 364, 383-84 (1984) (First Amendment prohibits laws motivated by "'a desire to curtail expression of a particular point of view on controversial issues of general interest'") (quotation omitted); *id.* at 407-08 (Rehnquist, J., joined by Burger, C.J., and White, J., dissenting) (agreeing with principle); *id.* at 414 & n.6 (Stevens, J., dissenting) (same); *Arkansas Writer's Project* v. *Ragland*, 481 U.S. 221, 234 (1987) (viewpoint discrimination impermissible); *id.* at 237 (Scalia, J., joined by Rehnquist, C.J., dissenting) (suggesting possibly "more stringent, prophylactic rule is appropriate, and can consistently be applied, when the subsidy pertains to the expression of a particular viewpoint on a matter of political concern . . ."); *Board of Educ.* v. *Pico*, 457 U.S. 853 (1982) (officials may not remove books from public school library because they disagree with the views expressed therein).

or a campaign for public office. *Buckley* v. *Valeo*, 424 U.S. 1, 90-108 (1976).

In no case involving Congress's power to choose which activities it wishes to subsidize, however, has this Court ever carved out any exception to the First Amendment's bedrock prohibition against viewpoint discrimination. In fact, the Court has taken pains to clarify that the government may not use its vast spending and taxing powers to reward or penalize fund recipients based on the views they wish to express. For example, in *Regan* v. *Taxation With Representation*, 461 U.S. 540 (1983), on which the courts below chiefly (and mistakenly) relied (Pet. App. 56a, 29a-30a), the Court upheld the denial of tax subsidies to non-profit organizations engaged in lobbying on the explicit understanding that the regulation at issue did not discriminate on the basis of the organization's viewpoint:

> The case would be different if Congress were to discriminate invidiously in its subsidies in such a way as to 'aim at the suppression of dangerous ideas.' . . . We find no indication that the statute was intended to suppress any ideas or any demonstration that it has that effect.

461 U.S. at 548 (quoting *Cammarano* v. *United States*, 358 U.S. 498, 513 (1959)). Similarly, in *Lyng* v. *International Union*, 108 S.Ct. 1184 (1988), which was relied on by the district court below (Pet. App. 29a) and involved Congress's decision not to provide striking workers with food stamps, the Court found no evidence of viewpoint discrimination and observed that Congress's intent was to "maintai[n] neutrality in private labor disputes." *Lyng*, 108 S.Ct. at 1193.

Even in those subsidy cases in which the Court has not expressly addressed the question of viewpoint discrimination, it is plain from the facts that no such issue was presented.[10] For example, in *Buckley* v. *Valeo*,

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[10] *Maher* v. *Roe*, 432 U.S. 464 (1977), and *Harris* v. *McRae*, 448 U.S. 297 (1980), involved legislative decisions not to fund the *performance* of abortions. Similarly, *Republican Nat'l Comm.* v.

424 U.S. 1, 90-93, 105-08 (1976), the Court upheld a campaign finance law that provided public funds only to those candidates who participated in party primaries. Such a restriction is plainly viewpoint-neutral. It is inconceivable that the Court would have upheld a campaign finance statute in which Congress conditioned the receipt of public campaign funds on the candidate's agreement not to use them to advocate reform of the campaign-finance laws. *Cf. id.* at 97 n.131. Similarly, while the Court reaffirmed in *Regan* Congress's right to choose not to subsidize lobbying activities generally, the Court surely would have invalidated a congressional statute that denied tax subsidies to groups who lobbied for a particular cause, such as greater environmental protection, but granted subsidies to groups that lobbied against that cause. See *Regan*, 461 U.S. at 548.

This Court's decisions therefore establish that (1) government has the right, through granting subsidies to particular types of activities but not others, to promote a partisan political agenda, but that (2) government is forbidden to promote such an agenda by conditioning the award of subsidies on the recipient's willingness to engage in or forgo the expression of particular views. The question presented here, accordingly, is whether the Secretary's regulations cross this constitutional line.

2. Other than the majority below, every court to consider the challenged regulations has found them to be viewpoint discriminatory.[11] As the Secretary concedes,

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Federal Election Comm'n, 487 F. Supp. 280 (S.D.N.Y.), *certified questions answered*, 616 F.2d 1 (2d Cir.), *aff'd*, 445 U.S. 955 (1980), relied on by the majority below (Pet. App. 56a), involved a decision not to subsidize the campaigns of candidates who received any private funding. Each of these cases involved a content-neutral decision by the government not to subsidize a particular activity.

[11] Supp. Pet. App. 41sa; *id.* at 30a-31a; *Planned Parenthood* v *Bowen*, 680 F. Supp. 1465, 1477 (1988) (regulations accord "preferential treatment to speech favoring childbirth"); *West Virginia Ass'n of Community Health Centers, Inc.* v. *Sullivan*, No. 2:89-0330, LEXIS 6180 (S.D. W. Va. 1990); see also Pet. App. 63a-64a (Kearse, J., dissenting).

the speech restrictions in question exhibit "a bias in favor of childbirth and against abortion." 53 Fed. Reg. at 2943. Section 59.10, for instance, does not forbid Title X grantees from engaging in political and lobbying activities generally, but only from engaging in those political and lobbying activities that advance a pro-abortion viewpoint. Section 59.8 goes even further: it compels speech that promotes the government's anti-abortion ideology as well as prohibits speech to the contrary.

The majority's "finding" below (Pet. App. 59a) that the new regulations do not discriminate on the basis of viewpoint is flatly inconsistent with the plain language of the regulations themselves. For example, the majority states that the regulations do not "in any way suggest that Title X funds may be used for public anti-abortion advocacy." But nothing expressly forbids it, while Section 59.10, by its terms, prohibits only speech that promotes abortion. The name of the provision alone reveals its viewpoint bias: § 59.10 is not a viewpoint neutral prohibition on public activity regarding abortion, but a self-proclaimed "[p]rohibition on activities that *encourage, promote or advocate abortion*" (emphasis added). Thus, Title X prohibits grantees: not simply from lobbying, but from "lobbying for . . . legislation to increase in any way the availability of abortion as a method of family planning," § 59.10(a)(1); not simply from providing speakers, but from "providing speakers to promote the use of abortion as a method of family planning," § 59.10(a)(2); and not simply from distributing materials, but from "disseminating in any way materials . . . advocating abortion as a method of family planning." § 59.10(a)(5). At the same time, Section 59.10 is silent on the use of funds for lobbying *against* the passage of pro-abortion legislation, providing speakers to *discourage* the use of abortion, and distributing materials *opposing* abortion.

Section 59.8 is also viewpoint discriminatory on its face. Rather than generally forbidding "argumentation pro or

con as to the advisability of an abortion," as the majority below erroneously suggests (Pet. App. 59a), the regulation selectively suppresses medical information about abortion while compelling speech that promotes its alternatives. Under § 59.8(a)(1), a Title X physician treating a pregnant patient may not provide her with nondirective, informational counseling about abortion. Nor may the doctor refer the patient to another health care facility that will provide abortion information and services. In fact, all referrals to prenatal, social service or emergency care facilities must exclude facilities that principally provide abortions. § 59.8(3). Without regard to the needs of the particular patient, the physician-patient dialogue is censored to eliminate any nonpejorative reference to abortion.

At the same time, §§59.8(a)(2) and (3) compel speech in furtherance of an anti-abortion viewpoint. Section 59(a)(2) compels physicians to refer all pregnant patients, whatever their medical circumstances, to prenatal care providers that "promote the welfare of mother and unborn child," and to give their patients all "information necessary to protect the health of mother and unborn child." Section 59.8(a)(3) requires physicians to provide referral lists (the same lists that may not include any regular abortion providers) that must include all "available providers who do not provide abortions" whether or not the physician judges them suitable for a particular patient.

Finally, contrary to the majority's assertion, § 59.8 does not require physicians to respond to requests for information on abortion merely with "the factual statement that the particular program does not include it as a family planning method . . ." Pet. App. 59a. Instead, § 59.8 requires Title X physicians to tell their patients that "the project does not consider abortion an *appropriate* method of family planning." § 59.8(b)(5), a statement which clearly expresses a normative judgment against abortion. Section 59.8 thus operates to compel

physicians to transmit a message of official disapproval of abortion while suppressing contrary information and views.

3. Even in cases involving "nonpublic forums," where government has wide latitude to determine the identity of the speakers and the content of the expression, "the government violates the First Amendment when it denies access to a speaker solely to suppress the point of view he espouses on an otherwise includible subject." *Cornelius* v. *NAACP*, 473 U.S. 788, 806 (1985); see *Perry Educ. Ass'n* v. *Perry Local Educator's Ass'n*, 460 U.S. 37, 46, 49 (1983). By requiring Title X physicians to engage in speech regarding pregnancy while forbidding them to speak about a legally available medical alternative to continuing a pregnancy to term, the Secretary's regulations "suppress the point of view [a physician] espouses on an otherwise includable subject." Government should not be permitted to use federal funds to engage in viewpoint discrimination in administering subsidies any more than in controlling its federally funded nonpublic forums.

The "need for absolute neutrality by the government" (*Young* v. *American Mini Theatres Inc.*, 427 U.S. 50, 67 (1976)) with respect to the expression of views is acute in any setting because of the government's unmatched ability to control public debate. As the Court explained in *City of Madison, Joint School Dist.* v. *Wisconsin Employment Relations Comm'n*, 429 U.S. 167, 175-76 (1976), "[t]o permit one side of a debatable public question to have a monoply in expressing its views . . . is the antithesis of constitutional guarantees."

To be sure, the government has not attempted to impose its regulations on every provider of family planning services. But as the Court has repeatedly stated, there is "'no general principle that freedom of speech may be abridged when the speaker's listeners could come by his message by some other means.'" *Arkansas Writers' Project, Inc.* v. *Ragland*, 481 U.S. at 231 (quoting *Virginia Bd. of Pharmacy* v. *Virginia Consumer Council*, 425 U.S.

748, 757 n.15 (1976). Moreover, the Court has repeatedly recognized that the practical availability of alternative channels of information bears on the reasonableness of even a content-neutral regulation of speech. *Perry Educ. Ass'n*, 460 U.S. at 53-4; *Cornelius*, 474 U.S. at 809. For the clients of Title X projects—women living at or near the poverty line and without access to alternative sources of medical information—the government's regulations may as well be universally applicable. Virtually by definition, the Secretary's regulations apply to clinics that serve women who do not have means available to "shop widely in the marketplace of ideas," consulting with a variety of public and private providers, in order to obtain complete information. Their Title X physician, and the referrals he or she provides, *are* their sole source of information. Through these regulations, the Secretary has ensured that for many women the only voice they will hear when attempting to decide whether to carry a pregnancy to term is government approved.

In sum, there is no question that government may make a value judgment favoring a particular public policy and may choose to promote that policy through its spending power. But the legitimacy of the government's ultimate goal does not empower the government to use means that are inconsistent with the First Amendment. The Secretary's regulations cross the line from a mere refusal to subsidize particular activities to an affirmative use of subsidies to promote one viewpoint and silence another. The regulations therefore are unconstitutional.

III. THE CHALLENGED REGULATIONS UNCONSTITUTIONALLY BURDEN THE FUNDAMENTAL RIGHT OF PATIENTS IN TITLE X PROGRAMS TO CHOOSE TO TERMINATE THEIR PREGNANCIES.

This Court has long recognized that the individual has a fundamental right, derived from the guarantee of liberty in the Due Process Clauses of the Fifth and Fourteenth Amendments, to have "independence in making certain kinds of important decisions." *Whalen* v. *Roe*, 429 U.S. 589, 599-600 (1977). At the core of this right

are decisions concerning procreation and marriage; "unwarranted government interference with freedom of choice" in making such inherently personal decisions is antithetical to basic concepts of individual liberty in the free society protected by our Constitution. *Harris* v. *McRae*, 448 U.S. 297, 317 (1980); see *Carey* v. *Population Servs. Int'l*, 431 U.S. 678, 685, 687 (1977); *Griswold* v. *Connecticut*, 381 U.S. 479 (1965).

The personal decisions protected by the Due Process Clause include both the right to terminate a pregnancy, *Roe* v. *Wade*, 410 U.S. 113 (1973), and more broadly, the right to be free of undue governmental interference in making important medical decisions. Just last Term, in *Cruzan* v. *Director*, No. 88-1503, slip op. at 13-15 (June 25, 1990), this Court reviewed the long common-law tradition upholding an individual's right to make informed decisions about medical treatment, and held that the Due Process Clause protects the right of individuals to "refus[e] unwanted medical treatment." *Id.* A logical corollary of the right to refuse treatment is the right not to be manipulated, deceived, or mislead into consenting to a course of treatment one might otherwise have refused.

In this case, the government defends against and the court of appeals rejected the due-process challenge to the regulations solely on the ground that government is not obligated to subsidize the exercise of constitutional rights. See *Maher* v. *Roe*, 432 U.S. 464, 474-76 (1977); *Harris* v. *McRae*, 448 U.S. 297, 316-18 (1980); 53 Fed. Reg. at 2935-36; Pet. App. 53a-59a. But *Maher* and *Harris* do not allow government to provide women with selective and potentially misleading information about their medical options and reproductive choices. Where, as here, such information will inevitably mislead women, the government has placed just the sort of "obstacl[e] in the path of a woman's exercise of her freedom of choice" that *Harris* and *Maher* prohibit. *Harris*, 448 U.S. at 316; see *Maher*, 432 U.S. at 473-74 (state may not impose "unduly burdensome interference with [woman's] freedom to

decide whether to terminate her pregnancy"); *cf. Webster* v. *Reproductive Health Servs.*, 109 S.Ct. 3040, 3060 (1989) (O'Connor, J., concurring) (state restriction that would "prohibit publicly employed health professionals from giving specific medical advice to pregnant women" would raise constitutional concerns).

By providing women with selective information, the regulations affirmatively interfere with and unduly burden a woman's exercise of her rights to choose whether to bear a child and to choose her course of medical treatment. As this Court and the common law have long recognized in a variety of contexts, the provision of selective information in a context where full disclosure may reasonably be expected is worse than providing no information at all. Accordingly, those in fiduciary relationships have a common law duty to disclose all material facts.[12] The state law of informed consent places a comparable duty on physicians, see *supra*, pp. 4-5. The doctor-patient relationship is founded on trust. A patient expects her physician to provide her with all of the information reasonably relevant to her decision. The court of appeals simply erred in failing to recognize how Title X patients, acting on this expectation, may be seriously mislead if given selective information.

First, the Secretary's regulations will mislead some women, particularly adolescents, into thinking that the medical system does not provide abortions. Contrary to the Secretary's assumption (53 Fed. Reg. at 2933), many women do not know whether abortion is a legal, practical, or safe medical alternative for them. See Pet. App. 87a, 91a, 92a, 95a (White ¶ 13; Potteiger ¶ 17; Rust ¶ 15; Merrens ¶ 15). For most of these women, the Title X clinic is their only source of health care information. *Id.* at 78a, 85a, 86a, 87a (Joseph ¶ 5; Fink ¶ 10; Coombs

[12] *Chiarella* v. *United States*, 445 U.S. 222, 227-28 (1980); see *Nader* v. *Allegheny Airlines*, 426 U.S. 290 (1976) (businesses must disclose material facts to consumers); *Basic Inc.* v. *Levinson*, 485 U.S. 224, 231-32 (1988) (issuers of securities must disclose all material facts to investors).

¶ 11; Morgan ¶ 6; White ¶ 15). To deny these women even basic information regarding the availability of abortion services is to tell them that such services do not exist. Rather than seek out other information sources, many of these women are likely to seek out unlicensed abortion providers or attempt dangerous self-abortions, thereby exposing themselves to potentially irreparable mental and physical harm. Pet. App. 92a (Rust ¶ 11).

Second, the Secretary's regulations will affirmatively mislead some women with complicating conditions to believe that continuation of a pregnancy is a medically safe and recommended option when in fact their health risks are serious. *See supra* pp. 7-9; Pet. App. 76a (Sammons ¶ 16). Physicians must counsel such women about "good health practices" (53 Fed. Reg. at 2937) and refer them to a prenatal care provider. Such counseling may leave a woman with the impression that her pregnancy poses no serious risks to her health—if not, why would her physician say nothing about an abortion? Like many women, she may delay going—or may never go—for prenatal counseling; even if her Title X physician is aware of a problem and concerned about delay, the physician may not advise her that pregnancy termination is an available option to consider.

Third, even women who are aware that abortion is a legal and safe alternative and who are interested in obtaining an abortion may be significantly burdened by the Title X physician's incomplete disclosure. By providing the patient with a list that includes some facilities—typically hospitals—that perform abortions, the regulations may lead a woman to believe that the list of facilities is comprehensive, and that her only source for an abortion is a hospital. For many low-income women, however, "[a]bortions performed in hospitals are generally prohibitively expensive." Pet. App. 82a (Henshaw ¶ 3); see Henshaw, *Freestanding Abortion Clinics: Services, Structure, Fees*, 14 Fam. Plann. Persp. 248, 249 (1982). Moreover, in many areas, the *only* provider of abortion services will be a clinic that primarily provides abortions, but those clinics are ex-

cluded from the Secretary's list of providers. See Henshaw, Forrest & Van Vort, *Abortion Services in the United States, 1984 and 1985*, 19 Fam. Plann. Persp. 63 65 (1987). Thus, at a minimum, the new regulations will significantly delay many women from obtaining an abortion, thereby substantially increasing their health risks.[13]

These harms—misleading women about the availability of abortions and the relative safety of carrying a pregnancy to term, and imposing upon women the health risks that accompany delay in obtaining full information—are substantially greater than those imposed by laws previously invalidated by this Court.[14] These regulations thus constitute the kind of "unwarranted government interference with freedom of choice" (*Harris* v. *McRae*, 448 U.S. at 317) that subject the government's actions to heightened judicial scrutiny.

Here, the government's sole justification is its interest in ensuring that the statutory "bias in favor of childbirth" and against abortion is fairly implemented by family planning clinics. The Secretary's enforcement concerns cannot possibly justify a regime in which women, in violation of state requirements, are denied candid conversations with their physicians and are

[13] See W. Hern, *Abortion Practice* 43 (1984); Cates, Schultz, Grimes & Tyler, *The Effect of Delay and Method Choice on the Risk of Abortion Morbidity*, 9 Fam. Plann. Persp. 266, 267 (1977); *Hodgson* v. *Minnesota*, No. 88-1125, slip op. 21 (June 25, 1990). The Secretary's attempt to justify the burdens of delay by reference to the ACOG recommendation that "a woman 'should be allowed sufficient time for reflection prior to making an informed decision'" (53 Fed. Reg. at 2938 (quoting ACOG Standards [6th ed.] at 63) reveals just how profoundly the Secretary misunderstands the informed consent process—it is only *after* the patient is aware of her options that any meaningful reflection can occur.

[14] See *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 443 (1983) (invalidating requirement that physicians recite a litany of abortion "facts"); *Thornburgh* v. *ACOG*, 476 U.S. 747, 762 (1986) (state-mandated provision of information "is the antithesis of informed consent").

forced instead to hear selective and misleading assessments of their treatment options. Forcing physicians to provide patients with incomplete medical information and thereby to violate the basic trust underlying the physician-patient relationship can never be a permissible means to any legitimate governmental interest.

* * * *

The Secretary's Title X regulations have gone well beyond what Congress has required and have created the kind of untoward legal consequences that warrant judicial condemnation. The regulations without justification directly intrude into and interfere with physician-patient relationships that historically have been governed exclusively by state law and place physicians in the dilemma of complying with state *or* federal law, but not both; the regulations discriminate on the basis of the speaker's viewpoint in a way that has been unfailingly rejected by this Court; and the regulations have created a significant obstacle to a woman's ability to exercise rights protected by the Constitution and state law. In sum, the regulations directly undermine the very purpose for which Title X was enacted: they impair rather than enhance the health of individuals who turn to those clinics for assistance. Because Congress never intended these results and the Constitution would not countenance them even if Congress had so intended, the regulations should be set aside.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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